DEVELOPING SELF-EVALUATIVE INFORMATION SYSTEMS: A GUIDE FOR COMMUNITY SERVICE MANAGERS

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PAPER #1

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INTRODUCTION

This guide is one of the products of a 1979 summer grant from the Secretary of State. It represents the first in a series of Social Planning and Research Council publications for community service managers.

It is designed to assist managers in utilizing their client record keeping systems as an evaluative resource. It represents one effort to bridge the gap between evaluative researchers and community service practitioners.

Despite the significant developments which have occurred in evaluation research during the past decade, there is a notable lack of trained evaluation researchers to assist administrators in the evaluation of their programs. At the same time, the manager is under considerable pressure from funders to implement program evaluation procedures.

This situation presents an obvious problem for community service managers insofar as they are being forced to develop evaluative systems without access to the required technical resources. As the demands for accountability increase, this problem will become more acute.

This publication will not attempt to turn every manager into an evaluation researcher. It will, however, attempt to present the manager with a general approach to evaluating their service. Specifically, it will demonstrate how client record systems can be used as an evaluative tool.

It is very important that we receive feedback about the adequacy of this publication. Given this feedback, we can revise future editions of this publication, as well as plan other publications in our community service management series. The last page of this guide is a questionnaire which we hope you will complete after you have read and, hopefully, used the guide. Please complete it and return it to the Research Director.

I. SELF EVALUATION AND ACCOUNTABILITY

No one working in the community services system needs to be told of the growing importance of accountability. Community service managers are increasingly being required to justify their services in terms which can be understood by funders and the public at large.

Any funded service has an obvious financial accountability insofar as it must account somehow for the money which it is spending. The standard agency budget, in audited form, performs this function in the traditional sense. At least it testifies to the fact that agency personnel are not absconding with the funds. As community service facilities have grown more complex, however, and the number of programs have multiplied, managers have been forced to go one level beyond the standard agency budget to program budgetting or, as it is sometimes called, functional budgetting.

The other area of accountability is, of course, program accountability. That is, given that the money is being spent as planned, are the resulting services effectively meeting the needs as planned? It is in this area, that of effectiveness, that program evaluation has been receiving increased attention.

When these two areas of accountability - financial and effectiveness - come together, then the issue is one of efficiency. Are these effective services being offered to the largest number of people at the lowest possible cost?

THE EVALUATIVE QUESTION

The present paper is primarily concerned with the effectiveness dimension and, consequently, program evaluation. Evaluative research, like all research, is concerned with the generation of information to answer certain questions and the typical evaluation question, as mentioned above, is - Is this program effective?

Experience has shown that, in general, that question is a poor one insofar as it begs a yes-or-no answer. Such an answer is rarely possible for a number of reasons.

Firstly, success is a very relative thing. Is a success rate of 30% a good or a bad success rate? This judgement depends upon at least three factors - what are the success rates of other programs; what kind of clients are being served; and what kind of staff resources is the agency able to invest to secure that success rate.

Secondly, any program is likely to be more successful with some kind of clients than others. Given a general lack of appropriate research, an agency does not even necessarily know what kind of clients they are most successful with. Additionally, given the mandate of most agencies, they are not necessarily able to restrict their intake to those clients having a better prognosis. Some managers, in fact, would argue loudly that such a restriction would be improper.

Following upon this point, Hayes-Roth et al (1972)* concluded that the essential question for evaluative research in the field of psychotherapy is - "What kind of patient problem is helped by what kind of treatment, for what kind of patient?". This is the evaluative question which will form the basis of this paper. If, at first reading, the question sounds somewhat confusing, it will be clarified and discussed in more depth later.

Given a workable question, the next issue is, of course, who should answer it? There has been considerable debate about this issue in the evaluation literature. Should evaluations be carried out by the agency, the funder or a third party? This depends, not surprisingly, upon the purpose of the evaluation itself.

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*Hayes-Roth, F.; Longabaugh, R.; Ryback, S. "The Problem-oriented medical record and psychiatry", British Journal of Psychiatry, 1972, 121: 27-34.

In the context of this paper, we are assuming that the agency should be evaluating itself. That is why we speak of self-evaluation.

Funder and third party evaluations are typically one-shot efforts designed, "once and for all" in a safe scientific manner, to indicate whether this program is effective or not. As reflected in the previous statement, they usually begin with the wrong question. As one-shot efforts, they are of limited utility to agency personnel who require more of a continuous monitoring type of process if they intend to use the results for making administrative decisions. Thirdly, evaluations must, to a certain extent, be tailored to the specific agency and, subsequently, evolve with the agency. Funder and third party evaluations rarely have this quality and, therefore, justify the manager's complaint that the results are sometimes irrelevant.

Our position, therefore, is that, although funder and third party evaluations do have a place, highest priority should be attached to the development of internal, on-going self-evaluative systems in agencies. Certainly, the funder and third party evaluation will dominate evaluation research until agencies are capable of self-evaluation.

Quantitative evaluations require a data-base from which the information can be generated. The data base within an agency is, of course, the client records. Unfortunately, most agencies do not have the kind of client records which are conducive to an adequate self-evaluation.

The purpose of this paper is to assist community service managers to develop an adequate information base for agency self-evaluation.

II. THE INFORMATION SYSTEM

The term "information systems" brings to mind, in many professionals, the prospect of expensive and complicated computer systems. This need not be the case. In fact, in many agency applications, the use of a computer would clearly be a case of "overkill" - a manual system would be much more appropriate.

All of the concepts discussed in this paper can be utilized in either a manual or automated computer system.

WHAT IS AN INFORMATION SYSTEM?

An information system is simply a collection of information which is continually updated (input) and utilized for some purpose (output). The information system which we will be discussing in this paper is statistically-based and, thus, we speak of a data base.

Different information systems differ in terms of their complexity and the need for computerization increases with the complexity. The amount of complexity varies with the amount of information in the system and the type of output or reporting which is required of it.

In developing your own system, keep it simple. If expansion is necessary, any information system can be expanded at a future date. Start small and start manual.

WHY HAVE AN INFORMATION SYSTEM?

This question, although a popular one, is actually redundant. Every agency does, in fact, have an information system. It is just a question of how that information system is utilized.

Any agency which keeps client files has an information system. These files are probably updated by the individual therapist or worker and utilized by them in the course of their day-to-day work. This

information may be recorded in a standard fashion with each recorder using the same bits or categories of information or it may be done in an unstandardized manner (i.e. case notes).

Such an information system is primarily designed for the use of the frontline therapist or worker. It allows them to keep up-to-date on their work, refreshes their memory and can provide for the "smooth" transfer of a client from one worker to another.

Its use, however, as an evaluative tool is limited. If one is to carry out an evaluation based on this type of system, one is almost forced to simply ask each worker's opinion of how successful his/her work is.

To be an effective evaluation tool, an agency information system must have the following characteristics.

1) Standardized input: All of the information entering the system must be standardized. That is, each therapist or worker must be using common terminology to allow for a summary of the information.

2) Continuous input: The information must be constantly updated (i.e. new cases added) in order to provide relevant summaries.

3) Continuous output: The summarized information must be published on a continual basis (i.e. monthly) to allow for an ongoing monitoring of agency performance.

THE COMPONENTS OF AN INFORMATION SYSTEM

As described above, an information system has three elementary components - input, analysis and output. The input is, of course, the information which is put into the system. The most frequent example of input is client data.

The analysis involves summarizing this information into a useful and clearly understood set of documents.

These documents are the output of the system. Other output mediums, particularly when the system is computerized, are available.

TYPES OF AGENCY INFORMATION

Most of the information contained in an agency can be classified into one of two types - resource data and client data.

Resource data is the information which describes the resources which an agency utilizes to deliver their service. This is expressed primarily in terms of finances and staff although, in some larger services, equipment and facilities become a major resource. Examples of resource data are - number of staff, cost per unit of service, etc.

Client data is that information which described the recipients of the service. This includes demographic information (age, sex, marital status, etc.); problem definition data (i.e. psychiatric diagnosis) and change data (information relating to the results of the service upon the client.

These two groups of information can be combined at the output stage. An example of this type of combination would be the cost/unit of service for family counselling clients.

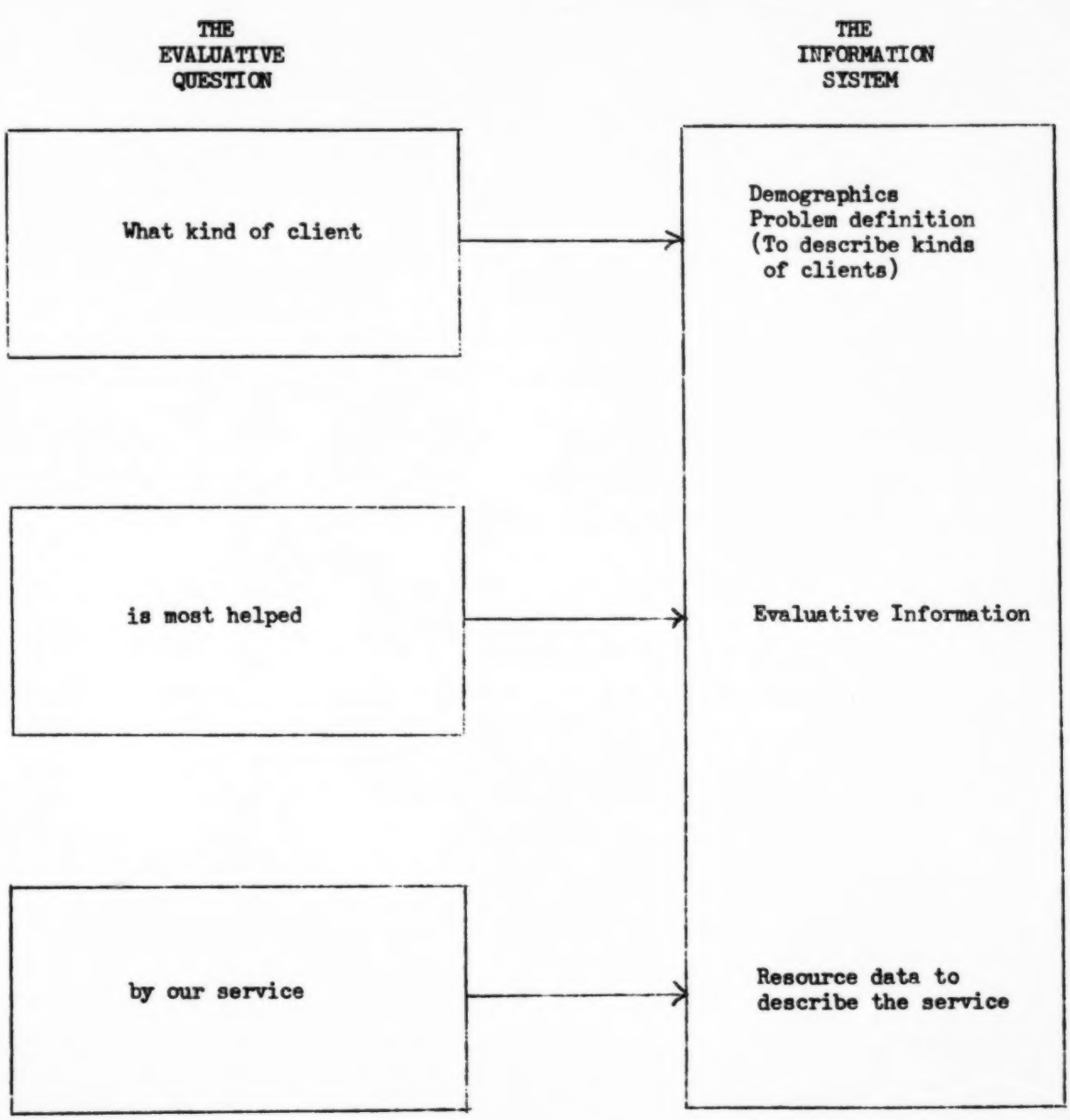
Most of this guide will be concerned with the utilization of client data as opposed to resource data.

PUTTING IT ALL TOGETHER

How then does this information relate to the evaluation question? For our purpose, we will simplify the evaluation question to - "What kind of client is most helped by our service?".

As presented graphically in Table I each type of agency information is relevant to one aspect of the evaluative question.

TABLE I


THE EVALUATIVE QUESTION
THE INFORMATION SYSTEM
What kind of client
is most helped
by our service
Demographics
Problem definition
(To describe kinds of clients)
Evaluative Information
Resource data to describe the service

III. CLIENT INFORMATION: DEMOGRAPHICS AND PROBLEM DEFINITION

DEMOGRAPHIC INFORMATION

Demographic information is the basic situational data which almost any agency keeps about their clients - age, sex, marital status, employment, education, etc.

For ease of analysis in an information system, this data should be categorized at the stage of input. Age can be categorized into age groups (i.e. 0-5, 16-18, 40-45, etc.) and the precise groupings used will depend upon the nature of the agency. The major consideration is to keep the number of categories at a manageable level. Thus, an agency which serves only 16 to 21 year olds may still record age on a single year basis insofar as they will only end up with six categories.

Sex, marital status and number of dependents or children are easily classified.

A useful classification for employment status is employed; unemployed; student; homemaker; inactive. Use the standard definition of unemployed - someone who does not have a job but is looking for work. as opposed to unemployed persons not looking for work. The latter would be classified as inactive.

Classify the individual's occupation according to the standard Statistics Canada occupational listing. This is presented in Appendix I of this guide.

A very useful demographic statistic which is seldom used by agencies is "location". Any urban area is divided into census tracts by Statistics Canada for use in the National Census. The City of Hamilton, for example, is divided into seventy-eight census tracts.

A street index is available from Statistics Canada which allows the user to very quickly identify the correct census tract for any address.

Alternatively, large urban areas are often divided into planning neighbourhoods or wards. Again, a street index is usually available from the area planning department for locating addresses. In Hamilton, we are fortunate insofar as the wealth of socio-economic data from the National Census has been recoded on the basis of planning neighbourhoods.

Geographical coding allows administrators to monitor where demand for their services is coming from. Additionally, by utilizing the socio-economic information from the National Census, the service planner can identify what kind of areas, in socio-economic terms, have a high demand for their particular service.

To start, however, it would be worth your while to go through the appropriate research literature to identify which demograhic characteristics have been found to be associated with treatment success in your service area. To a considerable extent, this can also be done intuitively. Make certain that these statistics are included in your demographic profile.

The demographic information kept by seven sample services in the local area is presented in Appendix II.

PROBLEM DEFINITION INFORMATION

In some standardized manner, the problem of the client has to be categorized. There are a number of systems available for doing this, and it obviously has to be tailored to the specific needs of the agencies.

Most psychiatric services utilize the standard diagnostic categories for mental disorders as developed by the American Psychiatric

Association. These are mental retardation, organic brain syndromes, non-physical psychoses, neuroses, personality disorders, psycho physiologic disorders, etc. and their numerous sub-categories.

For non-psychiatric social services, there are a number of possible systems. Considerable work has been done in this regard in the area of "problem-oriented record keeping". One of the more complex systems is that of Richard Grant. He devised a "problem coding system" which operates at four levels of differentiation and specifies over 200 specific problem areas. The Grant system is actually a combined psychiatric-social service diagnostic scheme.

The problem definition systems of three local services, by way of illustration, are presented in Appendix III of this guide. It is obvious when reading these schemas that each reflects the unique mandate of each agency.

Thus, the precise categories have to be tailored to the individual agency. Regardless, however, of which categories are used, they must be defined in very specific terms to meet the criteria of standardization.

When the problem definitions are used to generate treatment goals, then the evaluation process is begun. Such a system is called a "goal-oriented records" system.

CODING THE INFORMATION

The analysis of this information can be greatly simplified if some system of "coding" is a applied. For example, if five age categories are used, these can be coded from one through five as in Figure I.

The same coding system can be applied to the various problem-definition categories.

The importance of this coding system will become more obvious in the section dealing with the analysis of the information.

FIGURE I

Age Categories	Code
16-19	"1"
20-24	"2"
25-29	"3"
30-34	"4"
35 & over	"5"

IV: CLIENT INFORMATION: EVALUATION OF CLIENT CHANGE

This body of information tends to be the most neglected area of agency record keeping because of the general complexity of evaluation research. In the initial development of an agency information system, however, there are a number of fairly simple approaches which can be taken. In this section of the guide, three of these methods will be briefly discussed - client satisfaction; goal attainment scaling and community adjustment follow-up questionnaires.

CLIENT SATISFACTION

Family Services of Hamilton-Wentworth employ a fairly simple measurement of client satisfaction. Based upon their problem definition system, caseworkers identify from one to three "target problems" upon which treatment will focus.

At termination, the client and counsellor independently rate the extent of success attained in dealing with each of the problems. The rating is performed on a four point scale, as follows:

Successful
Partially successful
Unsuccessful
Unknown

The Client Satisfaction Questionnaire utilized by the Harris County Mental Health and Mental Retardation Authority in Houston, Texas is presented in Table II. This goes slightly further than the previous approach insofar as it deals with specific aspects of the service provided.

TABLE II: HARRIS COUNTY CLIENT SATISFACTION SCALE

1. Did you have trouble:
   a) Making an appointment?
   b) Getting into a treatment program?
   c) Did you pay for services?
   d) Were agency personnel responsive?

2. The treatment or services are helpful because of:
   a) Medication
   b) Specific advice received
   c) Increased self understanding
   d) Adequate testing and proper placement

3. Are you:
   a) Receiving good services?
   b) Satisfied with your therapist, counsellor or caseworker?
   c) Satisfied with the hours the unit is open?
   d) Do you prefer evening hours?

4. If you had a choice, would you continue services at H.C. Mental Health and Mental Retardation Authority?

NOTE: All items answered on a yes/no basis.

Source: Justice, B., McBee, G. "A Client Satisfaction Survey as One Element in Evaluation", Community Mental Health Journal, Vol. 14 (3), 1978, 248-252.

At a slightly more detailed level, the client satisfaction questionnaire from an American Health maintenance organization is presented in Table III. Although this questionnaire is designed for use in a health organization, most of the items, some with minor changes, could be applied to non-health oriented services.

GOAL ATTAINMENT SCALING

Goal attainment scaling (GAS) is a logical extension of problem oriented record keeping whereby client problems are translated into treatment goals and the level of goal attainment is subsequently monitored.

In standard GAS format, each goal is scaled on five possible outcomes ranging from "best possible" to "worst possible" with corresponding numerical values ranging from +2 to -2 with a mid-point of 0 (expected outcome). The clients level of attainment at intake is marked on the goal attainment form and, subsequently, at discharge and post-discharge follow-up, the outcome level is recorded. A goal attainment score is then calculated, based upon the changes between intake and discharge.

More than one goal is typically utilized for each client and each goal can be given a numerical weighting which reflects its relative importance for the individual client. This weighting system can be included in the calculation of the goal attainment score.

A standard goal attainment format, as utilized by a local youth services agency is presented in Table IV.

For further reading, a goal attainment scale bibliography is included in Appendix IV of this report.

TABLE III: CLIENT SATISFACTION SCALE

All questions answered as "satisfied, neutral or dissatisfied".

1. Technical knowledge, ability, competence of doctors.
2. Personal interest and attention given by doctors.
3. Attitudes and behavior of nurses, receptionists, cashiers, appointment clerks, other staff.
4. Length of time between calling and date of appointment.
5. Message center for contacting doctor.
6. Amount of time spent on telephone with appointment or message center
7. Hospital care
8. Getting care in an emergency
9. Getting care without appointment
10. Getting preventive care, e.g., physical exams.
11. Amount of time spent with doctors
12. Amount of explanation or information from doctors
13. Costs in comparison to services covered
14. Appearance, layout, design of clinics
15. Location of facilities

Source: Pope, C.R. "Consumer Satisfaction in a Health Maintenance Organization", Journal of Health and Social Behavior, Vol. 19, 1978, 291-303.

TABLE IV: MODIFIED GOAL ATTAINMENT FOLLOW-UP GUIDE

CLIENT_____ A.Y. COUNSELLOR_____

Level at Intake ✓ Follow-up ✗

	EMPLOYMENT	FAMILY RELATIONSHIPS	EDUCATION	ALCOHOL AND/OR DRUGS	CRIMINALITY	ACCOMMODATION	MONEY MANAGEMENT	COMMENTS
1	Unemployed and no vocational goals	Client has lost all contact with family	Client is not at functional reading level and has made no effort to improve	Client is addicted to alcohol and/or drugs	Client has been in jail and has charges pending	Client is walking streets at night	Client is broke within a few days after receiving his cheque	
2	Unemployed but has vocational goals	Client has established occasional contact	Client has enrolled in school, but dropped out	Client uses drugs and drinks to excess	Client is involved in crime but has not been caught as yet	Client has made arrangements to stay at Salvation Army, Good Shepherd, etc.	Client gives his worker some money to keep for later in the month	
3	Employed but quit before three maths	Client is in regular contact with family and is receiving counselling	Client has enrolled in school but not attending classes on a regular basis	Client uses drugs and drinks socially	Client is making an effort to stay away from crime	Client has own room and has lived there for a month	Client, in most cases, makes his money last until next cheque	
4	Employed but no real interest in job	Client has regular family contact, and the family is receiving counselling	Client has attained grade ____ level with no vocational goals established	Client does not use drugs, but drinks socially	Client has been clear of crime for six months	Client has room he likes and is living in it on a steady basis	Client budgets the use of his money	
5	Employed a job he enjoys	Client has established satisfactory family relationship	Client has mastered grade _____, and has established vocational goals	Client is not using alcohol or drugs	Client has been clear of crime for one year and does not talk of doing it	Client has apartment or room with telephone under his name	Client budgets his money and saves on a regular basis	

COMMUNITY-BASED FOLLOW-UP QUESTIONNAIRES

Traditional evaluation, particularly in the field of mental health has tended to concentrate upon changes in the psychological characteristics of the individual. Thus, for example, the Minnesota Multi-phasic Personality Inventory (MMPI) has often been utilized to measure changes in psychiatric symptoms as a result of treatment.

Two major problems were associated with this approach. Firstly, tests such as the MMPI require highly trained personnel for interpretation. Unless a social service agency employed psychologists, this type of testing was not available to them.

Secondly and, more importantly, the results of these psychological tests did not indicate how the client actually functioned in the community after discharge. They only indicated how the client's personality or psychiatric symptons had changed. As a result of the emphasis of social service agencies upon "community adjustment", these tests were of limited utility.

During the last decade, however, the rapid development of the community mental health movement and the subsequent growth of community mental health centres has resulted in the development of a number of fairly sophisticated community adjustment inventories. These tests are specifically designed to measure how the discharged client is functioning in the community.

One of the most popular of these scales, at present, is the Denver Community Mental Health Questionnaire. This seventy-nine item questionnaire measures eight major dimensions of community adaptation - psychological distress, isolation from family, isolation from friends, productivity, public system dependency, alcohol abuse, drug abuse and client satisfaction.

A second popular questionnaire for this purpose is the Community Adaptation Schedule, a 217 item inventory which measures a number of community adjustment dimensions as well as individual affective, behavioral and cognitive traits. The community adjustment scales are work community, family community, social community, larger community, commercial community and professional community.

This questionnaire, because of its considerable length, is somewhat more arduous to use than the Denver scale. Scoring is also considerably more complicated.

References for these questionnaires are provided in Appendix IV of this report.

SUCCESS AND NUMBERS

To be used statistically, the evaluative information obviously has to be expressed numerically.

Client satisfaction can be calculated as an "average satisfaction score" based upon the responses to the questionnaire.

Goal attainment scaling leads to a goal attainment score for each client.

The community functioning questionnaires are usually used in a "before and after" format. Each client has an average score on each scale at intake, another average score at discharge and, hopefully, another score three to six months after discharge as a follow-up. Thus, each client is administered the scale at least twice. The change in the client scores is the indicator of success. For example, one would hope for a decrease in the "Psychological Distress" score from the Denver Community Mental Health Questionnaire.

Each one of these methods, then, can generate a clear numerical indicator of outcome or success.

V: LINKING THE COMPONENTS: THE DATA ANALYSIS

The previous two chapters have dealt with the preparing of the information as the "inputs" of the information system. This information must now be analyzed to produce the proper summary documents.

Firstly, the information must be stored in a manner which is amenable to analysis. If it simply remained in the client files, then it would be necessary to go through every file to obtain the necessary data. This is obviously impractical.

For this reason, most agencies utilize a master sheet which contains all of the coded information. To ensure confidentiality, a "case number" is used instead of the client's name. This case number, which is a unique number assigned to the client at intake, also appears on the client file. This number is the only link between the master sheet and the file.

An example of a simple master sheet is presented in Table V.

Given a master sheet, the data can then be analyzed in a number of different ways. If the data is analyzed manually, then the calculations can be made directly from the sheet. If a computer is used, the data is usually transferred from the master sheet to a computer coding form which the key puncher uses to transcribe the data onto computer punch cards.

A NOTE ON COMPUTERS

If you do have access to a university computing centre, check into the cost of having your data computer analyzed. Very little programming sophistication is required. For the kind of analysis recommended in this guide, the "canned programs" included in the Statistical Package for the Social Sciences (SPSS) are more than adequate. Most university computing centres have these programs on hand.

TABLE V: SIMPLIFIED SAMPLE MASTER SHEET

GAS Score 2	
GAS Score 1	
Problem Areas* 4	
3	
2	
1	
Date of Follow-up	
Date of Discharge	
Date of Intake	
Occupation	
Employment	
Education	
Dependents	
Marital Status	
Sex	
Age	
Case Number	

*NOTE: Opportunity given for inclusion of more than one problem-area for each client. When this is done, some order of priority among the different problems should be indicated. On this sheet, they would be ranked 1, 2, 3, or 4.

The computer time itself is a minimal cost amounting to only a few dollars. You will need a programmer to "tell" the computer what SPSS program to use and what form you want the output to take. You will also need someone to do the keypunching. Often you can find a graduate student or a faculty member who can do this for you either free or at a small cost, i.e. $100.00.

THE MCBEE SYSTEM: A MANUAL COMPUTER

The McBee Company has a system of punched cards which can be used to store the data and greatly eases the task of analysis. At least three agencies in Hamilton-Wentworth are using the McBee system with considerable success - Volunteer Bureau, Wesley House and Project LONAR.

A sample McBee card is presented in Table VI.

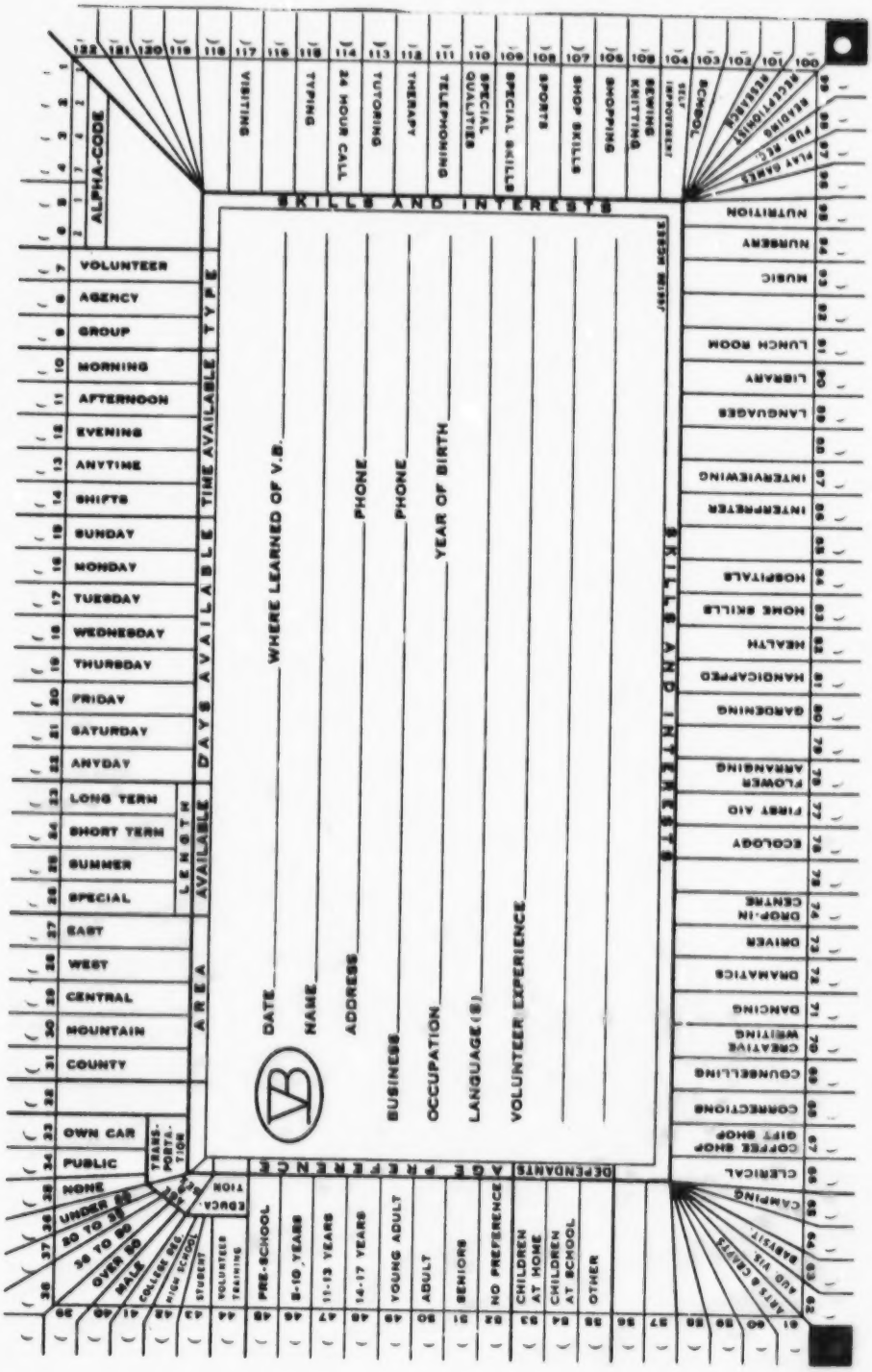
The data is transferred onto the cards by "opening up" the appropriate holes with a special punch. One thousand printed McBee cards cost between $200 and $250. This allows for the storage of data for 1,000 clients.

ANALYZING THE DATA

Whatever system you use, the analysis is relatively straight forward. Based upon the evaluative question discussed earlier in this guide, the purpose of the analysis is to discover which demographic and problem definition variables "predict" treatment success. The variables which are associated with success form the profile of the type of client which is most helped by your service. The evaluative data is, of course, your indicator of success.

In the hypothetical example presented below, we will use "client satisfaction" as our indicator of success.

TABLE VI


SKILLS AND INTERESTS
ALPHA-CODE
VOLUNTEER
AGENCY
GROUP
MORNING
AFTERNOON
EVENING
ANYTIME
SHIFTS
SUNDAY
MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY
ANYDAY
LONG TERM
SHORT TERM
SUMMER
SPECIAL
EAST
WEST
CENTRAL
MOUNTAIN
COUNTY
OWN CAR
PUBLIC
NONE
UNDER 20
20 TO 30
30 TO 50
OVER 50
MALE
COLLEGE GRS
HIGH SCHOOL
STUDENT
VOLUNTEER TRAINING
PRE-SCHOOL
6-10 YEARS
11-13 YEARS
14-17 YEARS
YOUNG ADULT
ADULT
SENIORS
NO PREFERENCE
CHILDREN AT HOME
CHILDREN AT SCHOOL
OTHER
VISITING
TYPING
24 HOUR CALL
TUTORING
THERAPY
TELEPHONING
SPECIAL QUALITIES
SPECIAL SKILLS
SPORTS
SHOP SKILLS
SHOPPING
KNITTING
SEWING
SELF IMPROVEMENT
SCHOOL
RECEPTIONIST
RESEARCH
PUB RELS.
PLAY GAMES
NUTRITION
NURSERY
MUSIC
LUNCH ROOM
LIBRARY
LANGUAGES
INTERVIEWING
INTERPRETER
HOSPITALS
HOME SKILLS
HEALTH
HANDICAPPED
GARDENING
FLOWER ARRANGING
FIRST AID
ECOLOGY
DROP-IN CENTRE
DRIVER
DRAMATICS
DANCING
CREATIVE WRITING
COUNSELLING
CORRECTIONS
COFFEE SHOP GIFT SHOP
CLERICAL
CAMPING
ARTS & CRAFTS
AVID VIS
BABYSIT
DATE
NAME
ADDRESS
PHONE
BUSINESS
PHONE
OCCUPATION
YEAR OF BIRTH
LANGUAGE(S)
VOLUNTEER EXPERIENCE
WHERE LEARNED OF V.B.
AREA AVAILABLE
LENGTH
DAYS AVAILABLE
TIME AVAILABLE
TYPE
TRANSPORTATION
EDUCATION
AGE PREFERENCE
DEPENDANTS
SKILLS AND INTERESTS

Firstly, you may want to ascertain whether the age of the client is associated with client satisfaction. Simply calculate the average client satisfaction score for all the clients in each age category. This will yield an "average success rate" for each age group. If the success rate is markedly higher in one group, then that age group appears to benefit more from treatment.

This procedure can be repeated with each demographic variable as well as each category used in the problem-definition system.

This is the most elementary form of analysis and more sophisticated forms can be used. For example, "cross-tabulation" can be utilized to identify if combinations of two variables are associated with success. Thus, for example, you may want to ascertain if "young marrieds" respond better than "young singles". At an even more complex level, a larger combination of demographic and problem oriented variables can be related to treatment success through "multiple regression techniques". As the level of sophistication increases, so does the need for computerization. If you do wish to use cross-tabulations or multiple-regression, consult with a qualified researcher.

To begin, however, the simpler method described in the previous paragraphs is quite adequate. The results of this analysis, however, may suggest more questions which require a more sophisticated analysis.

* * * * * * *

APPENDIX I

STATISTICS CANADA
MAJOR OCCUPATIONAL CLASSIFICATIONS

TWO DIGIT CODES

11	Managerial, Administrative and Related
21	Natural Sciences, Engineering and Mathematics
23	Social Sciences and Related Fields
25	Religion
27	Teaching and Related
31	Medicine and Health
33	Artistic, Literary, Performing Arts
37	Sports and Recreation
41	Clerical
51	Sales
61	Service
71	Farming and Argricultural
73	Fishing, Hunting and Trapping
77	Mining and Quarrying
81/82	Processing
83	Machining and Related
85	Product Fabricating, Assembling and Repairing, Labour
87	Construction Trades
91	Transport Equipment Operating
93	Meterial Handling
94	Other crafts and equipment operating
99	Occupations not elsewhere classified

APPENDIX II

DEMOGRAPHIC DATA
IN
SEVEN LOCAL AGENCIES

A survey of seven large local agencies indicated that all of the agencies collected the following demographics:

1. Birthdate
2. Sex
3. Education
4. Marital Status
5. Occupation/Employment
6. Income

Some of the agencies also collected the following:

1. Religion
2. Family names and age
3. Language spoken
4. Type of Residence
5. Criminal Record
6. Race
7. Ethnic Origin

APPENDIX III

THE PROBLEM DEFINITION SYSTEMS OF THREE LOCAL AGENCIES

FAMILY SERVICES OF HAMILTON-WENTWORTH

DEFINITIONS: FORM 2 - PROBLEM IDENTIFICATION

GENERIC PROBLEM DESCRIPTION

The following describe the general types of problems as assessed by the worker.

Interpersonal relationships : familial, includes relationship problems among any or all family members (adult partners, parent(s) and child(ren), etc.).

Interpersonal relationships : extra familial, includes relationship problems between member(s) of family and person(s) outside the family.

Individual adjustment indicates that the problem (in terms of personality, behaviour or adjustment) lies within the individual client.

Practical living skills implies that the problem area involves a lack of knowledge or inability to apply knowledge related to every day living exclusive of problems connected to financial management.

Environment implies that the problem area is connected to or stems from societal, environmental or situational factors.

Health and welfare implies that the problem area is specifically connected to, or stemming from, health or care factors.

Financial management indicates that the problem area is connected to money management, such as use of credit, inability to meet obligations to creditors, budgeting, priorities and planning.

IDENTIFIED COMPONENTS

The following describes the problem components as assessed by the workers after the intake phase.

Emotional maladjustment/withdrawal. Includes such related problems as: difficulty in facing issues and in handling emotions involved with these issues; reactive or pervasive depression (excluding defined psychiatric illness); isolation (physical and/or emotional); and difficulty in articulating and communicating thoughts or emotions (including perceptural difficulties).

Low self-esteem. Beyond "Emotional maladjustment/withdrawal", indicates an acute sense of discouragement/failure, possibly combined with a low degree of motivation.

Social contacts or use of leisure time. Destructive or inappropriate use of leisure time/or conflict in family as a result of this.

Identified child abuse. Evidence recorded with a child welfare agency that parent has abused or neglected child, physically and/or emotionally.

High risk for child abuse. The situation/emotional climate is such that child abuse or neglect is a high probability.

Adjustment to separation/family breakup. Includes adjustment to marriage breakup, to child leaving home, parent leaving home or death in the family.

Conflict concerning separation decision. Refers to problems in making decision to separate.

Sexuality. Includes all problems (in terms of knowledge, behaviour or attitude) relating to sexuality.

Pregnancy. Refers to any pregnancy which results from or produces conflict.

Addiction. Includes conflict (external or internal, within group, society, or individual) caused by dependence on alcohol, drugs, or gambling (specified by worker.

Occupational problems. Doing poorly at work, difficulty in holding a job, or being in an unsuitable job; excludes lack of available employment.

School problems. Poor academic performance, truancy, misbehaviour, or poor peer relationships at school.

(Potential) conflict with law. Includes delinquent/criminal/anti-social behaviour when the client has been in conflict with the law or there is a distinct possibility of this occurring.

Parenting. Includes inconsistency in disciplining or rewarding children, conflict or rebellion; more generally this implies a lack of knowledge about the normal development (physical or emotional) of a child.

Domestic management. Includes problems with taking care of house, meals, inability to plan time realistically in this area, or lack of knowledge about nutrition.

Money management. Client lacks the capacity to correlate income realistically to a comprehensive range of basic budgetary needs and obligations. As a consequence, income is allocated so inappropriately that certain basic needs and/or obligations to creditors are left inadequately provided for.

Cultural adjustment. Refers to problems complicated by ethnic or regional background, including language-related difficulties within either individual or community.

Accessibility of existing community resources. Includes lack of knowledge about existing community resources, or need for assistance in carrying out contact with resource.

Inadequate education/training. Employment opportunities are scarce or unsuitable because of lack of education, experience, and/or job-related training or problems related to re-entry into work force.

Restructured family. Family in which one or more of the parents have been previously involved in another marriage/union; often involves children, extended family, etc. from both the present and previous unions.

Unrealistic expectations. Client's aims/goals cannot be legitimately realized within the context of his/her circumstances (personal, environmental or financial).

Poor Planning. Client lacks ability to foresee or to provide realistically for future (personal, environmental or financial).

Change in circumstances. Significant change creates anxiety or conflict whether personal, environmental or financial.

Poor occupational opportunities. Employment or training opportunities are scarce or unsuitable because of conditions existing within community.

Inadequate services. Includes deficiency within community such as housing, health resources, social services, day care services, nursing homes or other services for the aged, recreational resources, transportation/mobility, or schools.

Bureaucratic obstacles - community/government services. Refers to blockages encountered with particular organization(s). Specify institution(s) concerned (including own organization, if applicable) and note potential scope of problem(s).

Illness/disability. Refers to long-term or incapacitating illness, physical handicap or defined psychiatric illness necessitating psychiatric assessment and/or treatment.

Inadequate income. Lack of money for food, housing, medical expenses and other necessities.

CHILDREN'S AID SOCIETY

Reasons for Admission

Emotional rejection
Housing
Imprisonment
Lack of income
Physical neglect
Unfit home
Lack of supervision
Marital conflict
No medical care
Physical abuse
Unwanted pregnancy
Parent-child conflict
Drug addiction
Alcoholism
Mental Illness
Mental Retardation
Physical Illness
Sexual Offences
Behaviour Problem
Child Offender
Court Order
Deserted
Orphan
Truancy

CHEDOKE CHILD AND FAMILY

PRESENT PERCEIVED PROBLEM

Classification of the patient's critical problem or problems at the time the patient is registered with CMHSIS. The various problem classifications are:

School & Learning - problems concerning truancy, school phobia, specific learning disability, academic performance seriously below apparent ability.

Thought & Perception - problems related to difficulty in concentration, delusions, hallucinations.

Disruptive Behaviour - problems related to hyperactivity, boisterousness, chronic lying, stealing, running away, temper tantrums, property destruction, aggression towards others, non-compliance with adults, attention seeking through negative behaviour, sexual acting-out.

Social Withdrawal - problems related to depression, withdrawal, lack of self-confidence, apathy, obsessive compulsive behaviour, secretive, self-inflicted injury or threat of same.

Bodily Functions - problems related to sleep, eating problems, nervous mannerisms, eneuresis, encopresis, speech difficulties, drug and/or alcohol problems.

Mental Retardation - any mental problems not specifically related to emotional mental problems.

Other (Family) - any problems not mentioned in any of the other problem classifications.

APPENDIX IV

BIBLIOGRAPHY

BIBLIOGRAPHY

Audette, D. & Petterson, N. "Experience in Follow-up Goal Attainment Scaling", Proceedings of the Second Goal Attainment Scaling Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Austin, N. "The Use of Goal Attainment Scaling in Community Mental Health Training and Implementation", Proceedings of the Second Goal Attainment Scaling Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Austin, N.; Liberman, R.P.; King, R.P. & Dekisi, W.J. "Goal Attainment Scaling Used to Compare Two Day Hospital's Behaviour Therapy with Mileu Therapy", Goal Attainment Review, Vol. 3, 1977, pp. 33-46.

Barron, N. & Bode, C.L. "Goal Attainment and Regionalized Alcohol Program Development", Goal Attainment Review, Vol. 1, 1974, pp 80-85,

Calsyn,R.J. & Davidson, W. "Do we really want a program evaluation strategy based soley on individualized goals?: a critique of Goal Attainment Scaling", in T.D. Cook, Evaluation Studies, Vol. 3, 1978.

Calsyn, R.J.; Tornatzky, L. & Dittmar, S. "Incomplete Adoption of an Innovation: The Case of Goal Attainment Scaling", Evaluation & Change, Volume 4, 1977, pp 127-130.

Cline, D.; Rouzer, D. & Bransford, D. "Goal Attainment Scaling as a Method for Evaluating Mental Health Programs", American Journal of Psychiatry, Vol. 130, January 1973, pp 105-108.

Cytrynbaum, S. "Goal Attainment Scaling, A Critical Review", Evaluation Quarterly, Vol. 3, No. 1, 1979, pp 5-40.

Cytrynbaum, S.; Birdwell, J.; Brandt, L. & Ginath, Y. "Goal Attainment Scaling: A Critical Review", Paper presented at the 85th Annual Convention of the American Psychological Association, San Francisco, Cal., 1977, August 26-30.

Davis, H.R. "Four Ways to Goal Attainment", Evaluation, Vol. 1, 1973 pp 43-48.

Dowd, L. & Kelly, F. "The Use of Goal-Attainment Scaling in Single Case Research", Goal Attainment Review, Vol. 2, 1975, pp 11-21.

Endicott, J.; Spitzer, R.; Fleiss, J. & Cohen, J. "The Global Assessment Scale", Archives of General Psychiatry, Volume 33, 1976, pp 766-771.

Galana, J. "Treatment Effectiveness as a Function of Client Involvement in Goal Setting & Planning", Goal Attainment Review, Volume 3, 1977, pp 17-32.

Garwick, Geoffrey. Advanced Topics in Goal Attainment Scaling, The Program Evaluation Resource Centre, Minneapolis, Minnesota, 55415, January, 1977.

Garwick, Geoffrey. "Defining and Validity Goal Attainment Scaling for Clients in Four Types of Outpatient Treatment", Proceedings of the Second Goal Attainment Scale Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Garwick, Geoffrey. "A Construct Validity Overview of Goal Attainment Scaling", P.E.P. Report 1969-73, 1974.

Garwick, Geoffrey. "An Introduction to Reliability and Goal Attainment Scaling Methodology", P.E.P. Report, 1969-73, 1974.

Garwick, Geoffrey. "Recent Findings on the Use of Goal Setting in Human Service Agencies: The Implementation, Flexibility, Validity of Goal Attainment Scaling", Goal Attainment Review, Vol. 1, 1974, pp 1-4.

Garwick, G. & Brintnall, J.C. An Introduction to Goal Attainment Scaling, Catalogue Assisted & The Ideal Book: 550 Indicators for Use in Setting Goals, Technical Assistance for Program Evaluation, Minneapolis, Minnesota, 1977.

Garwick, G. & Lampman, S. Dictionary & Index of Goal Attainment Scaling Conference, Unpublished Project Report, 1971.

Garwick, G.; McCree, S. & Brintnall, J. Bibliography on Goal Attainment Scaling and Associated Methodologies, 1976.

Goodyear, D. & Bitter, J. "Goal Attainment Scaling as a Program Evaluation Measure in Rehabilitation", Journal of Applied Rehabilitation Counselling, Vol. 5, No. 1, 1974, pp 19-26.

Hall, J. & Mathison, M. "Adaption of Goal Attainment Scaling to an Outpatient Drug Treatment Program", Goal Attainment Review, Vol. 2, 1975, pp 109-115.

Hegion, A.; Fish, E. & Grace, S. "Goal Attainment Scaling: An Alternative for Measuring Academic Progress", Goal Attainment Review, Vol. 1, 1974, pp 20-34.

Jacobs, S. & Cytrynbaum, S. "Goal Attainment Scaling on CMHC Inpatient Crisis Intervention Unit", American Psychological Association, 1976.

Jones, S. & Garwick, G. "Guide to Goals Study: Goal Attainment Scaling as a Therapy Adjunct?", Program Evaluation Project Newsletter, Vol. 4, No. 6, 1973, pp 1-3.

Kaplan, J.M. & Smith W.G. "The Use of Goal Attainment Scaling in the Evaluation of a Region Mental Health Program", Community Mental Health Journal, Vol. 13, No. 2, 1977, pp 188-193.

Kiresuk, T.J. & Sherman, R. "Goal Attainment Scaling: A General Method for Evaluating Comprehensive Community Mental Health Programs", Community Mental Health Journal, Vol. 4, 1968, pp 443-453.

Kiresuk, T.J. & Lund, S.H. "Process & Outcome Measurement Using Goal Attainment Scaling", Evaluation Studies Review Annual, Glass, G.V. (ed.), Beverly Hills, Cal., Sage Publications, Inc., Vol. 1, 1976.

Kiresuk, T.J. "Goal Attainment Scaling at a County Mental Health Service", Evaluation, Special Monograph, Vol. 1, 1973, pp 12-18.

Kiresuk, T.J. & Lund, S.H. "Goal Attainment Scaling", Evaluation of Human Service Programs, C.C. Attkisson, W.A. Hargreaves, M.H. Horowitz & N.J.E. Sorense (eds.), N.Y., San Francisco: London Academic Press, 1978.

Laferriere, L. & Calsyn, R. "Goal Attainment Scaling: An Effective Treatment Technique in Short-term Therapy", American Journal of Community Psychology. In press.

McGaghie, W. & Menges, R. "Goal Attainment Scaling in Psychological Education", Goal Attainment Review, Vol. 2, No. 2, 1975, pp 3-32.

Miller, G. & Mandel, H. "A Varient of Goal Attainment Scaling: Progast", Evaluation, Vol. 1, No. 3, 1973, pp 17-18.

Nevid, J.S.; Morrison, J.K. & Gaviria, B. "Problem-Oriented Goal Attainment Scaling on a Satellite Community Mental Health Team", Emerging Developments in Mental Health Program Evaluation, W. Neigher, R.J. Hammer, G. Landsberg, (eds.), New York, Argold, 1976.

Putnam, D.G.; Kiesler, D.J.; Bent, R.J. & Stewart, A. "Goal Attainment Scaling Training Manual", Unpublished Manuscript, Drug Abuse Services Section, Georgia, Department of Human Resources, 1973.

Ricks, F. & Weinstein, M. "The Influence of Modified Goal Attainment Scaling Procedures on Treatment Outcome", Goal Attainment Review, Vol. 2, 1975, pp 65-70.

Sherman, R. "The Content Validity Argument for the Validity of the Goal Attainment Score", Proceedings of the Second Goal Attainment Scaling Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Sherman, R.; Baxter, J. & Adette, D. "An Examination of the Reliability of the Kiresuk-Sherman Goal Attainment Score by Means of Components of Variance", P.E.P. Report, 1969-1973, 1974.

Sherman, R. "Will Goal Attainment Scaling Solve the Problems of Program Evaluation in the Mental Health Field?", Program Evaluation for Mental Health Methods, Strategies, Participants, R.D. Coursey (ed.), New York, 1977.

Smith, D.L. "Goal Attainment Scaling as a Adjunct to Counselling", Journal of Counselling Psychology, Vol. 23, No. 1, 1976, pp 22-27.

Speer, D. & Cohen, E. "Goal Attainment Scaling in a Crisis Service: A Feasibility Study that Needs to be Done", Goal Attainment Review, Vol. 2, 1975, pp 79-98.

Stelmachers, Z. "Goal Attainment Scaling and the Crisis Intervention Centre", Proceedings of the Second Goal Attainment Scaling Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Swanstrom W. & Hedberg, L. "Broadening the Use of Goal Attainment Scaling in Residential Treatment: Moving Toward a More Complete Program Evaluation Design", Goal Attainment Review, Vol. 1, 1974, pp 49-54.

VanHoudnos, H. "Developing a Training Program for Goal Attainment Scaling", Proceedings of the Second Goal Attainment Scaling Conference, G. Garwick & J. Brintnall (eds.), Minnesota, 1974.

Wallin, P. & Koch, M. "The Use of Goal Attainment Scaling as a Method of Evaluating Clinical Outcome in an In-patient Child Psychiatry Service", Journal of the American Academy of Child Psychiatry, Vol. 16, No. 3, pp 439-445.

Weinstein, M.S. & Ricks, F.A. "Goal Attainment Scaling: Planning & Outcome", Canadian Journal of Behavioural Science, Vol. 9, No. 1, 1977, pp 1-11.

Willer, B. "The Relationship of Goal Attainment Scores and Client Involvement in Goal Setting to Inpatient Therapeutic Outcome", Goal Attainment Review, Vol. 2, 1975, pp 53-64.

Willer, B. & Miller G. "On the Validity of Goal Attainment Scaling as an Outcome Measure in Mental Health", American Journal of Public Health, Vol. 66, No. 12, 1976, pp 1197-1198.

Windle, C.; Schwitzgebel, R.L.; Zusman, J. & McPhee, C. "Goal Attainment Scaling for Research Monitoring", Goal Attainment Review, Vol. 1, 1974, pp 89-91.

Wood, W. "Content Analysis of Goal Attainment Scaling for an Outpatient Alcoholism Intervention Program", Goal Attainment Review, Vol. 2, 1975, pp 117-136.

Zil, J. Correlating Laterality of Goal Setting with Goal Attainment, School of Epidemiology & Public Health: Yale, 1977.

POOR

QUALITY

ORIGINAL